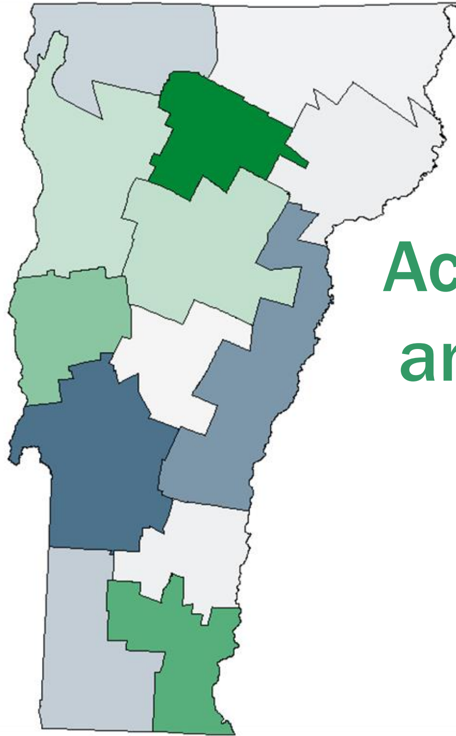

Update:
Accountable Care Organization Regulation and All-Payer ACO Model Implementation

April 10, 2019

Melissa Miles
Marisa Melamed
Michele Degree
Sarah Lindberg

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Agenda

Accountable Care Organization (ACO) Regulatory Update

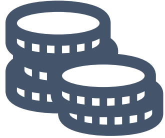
- 2019 ACO Budget Monitoring
- Planning for 2020 ACO Budget Review and ACO Certification

Vermont All-Payer ACO Model Agreement Update

- All-Payer ACO Model Reporting Timeline
- Federal APM Evaluation Update
- 2020 Medicare ACO Initiative
- Updates on Model Goals
  - Quality and Health Outcomes
  - Scale Targets
  - Financial Performance

Demonstration: Interactive Total Cost of Care Tool

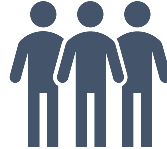
Reminder:
The Vermont All-Payer ACO Model



Test Payment Changes

Population-Based Payments Tied to Quality and Outcomes

Increased Investment in Primary Care and Prevention



Transform Care Delivery

Invest in Care Coordination

Incorporation of Social Determinants of Health

Improve Quality

Improve Outcomes

Improved access to primary care

Fewer deaths due to suicide and drug overdose

Reduced prevalence and morbidity of chronic disease

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ACO REGULATORY UPDATE

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Update: 2019 ACO Budget Monitoring

Quarterly and Semiannual Reporting

Quarterly Reporting

- Financial statements (balance sheet, income statement, cash flow)
  - Administrative expense ratio
  - Population health management/payment reform program investments
  - $3.9M in reserves by 12/31/19
- Updated policies and procedures, for certification

Quarterly Period (Reporting Date)	
Q1	Jan 1-Mar 31 (April 30)
Q2	Apr 1-Jun 30 (July 31)
Q3	July 1-Sept 30 (Oct 31)
Q4	Oct 1-Dec 31 (Jan 31)

Semiannual Reporting

- Complaint and grievance by payer
- Performance monitoring (attribution by payer, risk to hospitals, financial performance by payer contract)

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Update: 2019 ACO Budget Monitoring

Annual Reporting and Reporting on New Programs

Financial

- Data for Payer Differential Report (Q1)*
- Interim financial report on 2019 Comprehensive Payment Reform Pilot (Q2)
- Final report on 2018 Comprehensive Payment Reform Pilot (Q3)
- Value Based Incentive Fund distribution methodology for 2020 (Q3)*

Population Health and Other Programs

- Scale target ACO initiatives report (Q1)*
- 2020 network development strategy and timeline (Q1)
- Quality improvement management workplan (Q1)
- Timeline for 2019 Plan to Address Childhood Adversity (Q1)
- Specialist Payment Pilot (Q3)
- Community Innovation Fund (Q3)

Update: Planning for 2020 ACO Budget Review and ACO Certification

2019 Timeline	Activities
April-May	• Internal development of ACO budget guidance and certification eligibility verification form
June	• GMCB staff present guidance to Board • Public comment on guidance
July	• Board vote on budget guidance • GMCB issues guidance
October	• ACO submits budget to GMCB • Public comment on budget/certification opens
October/November	• ACO budget presentation to the Board
December	• GMCB staff presents analysis to the Board • Public comment closes • Board vote

VERMONT ALL-PAYER ACO MODEL AGREEMENT UPDATE

APM Model Evaluation Update

- Per Section 17 of the Agreement (*CMS Evaluation*), CMS shall evaluate and monitor the Model using mixed methods (see next slide)
  - Evaluation is being conducted at multiple levels (beneficiary, ACO, and state) in a way that recognizes the multitiered accountability and incentive structures inherent in the All-Payer model with ACO and non-ACO providers

- The evaluator is NORC of the University of Chicago[1]
  - NORC is also the evaluator of the Medicare Next Generation Program[2]

- Current timeline
  - Planning period: January-June 2019
  - First Vermont site visit: June 2019

[1] Vermont All-Payer Model Evaluation. http://www.norc.org/Research/Projects/Pages/vermont-all-payer-aco-model-evaluation.aspx.
[2] First Annual Report: Next Generation Accountable Care Organization (NGACO) Model Evaluation, August 27, 2018. https://innovation.cms.gov/Files/reports/nextgenaco-firstannrpt.pdf.

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Initial APM Evaluation Design

Evaluation Questions:

- How and why the model is successful, including implementation challenges and successes
- Potential replicability in other settings (e.g., states, communities, nationwide)
- Statewide spending (Medicare, Medicaid, commercial, and all-payer)
- Impact on population health and claims-based outcomes
- Delivery system and process measures
- Measures of health-care utilization, spending, and quality of care

Methods:

- Primary and secondary data sources
- Vermont's reports on scale, total cost of care, and quality of care submitted to CMMI per the Agreement
- Interviews, data review, audits, site visits, and any additional documentation
- Multiple quasi-experimental design methods (synthetic control methods, difference-in-differences with group-specific time trends, and generalized synthetic control)

For more information, see: Vermont All-Payer Model Evaluation. http://www.norc.org/Research/Projects/Pages/vermont-all-payer-aco-model-evaluation.aspx.

2020 Vermont Medicare ACO Initiative

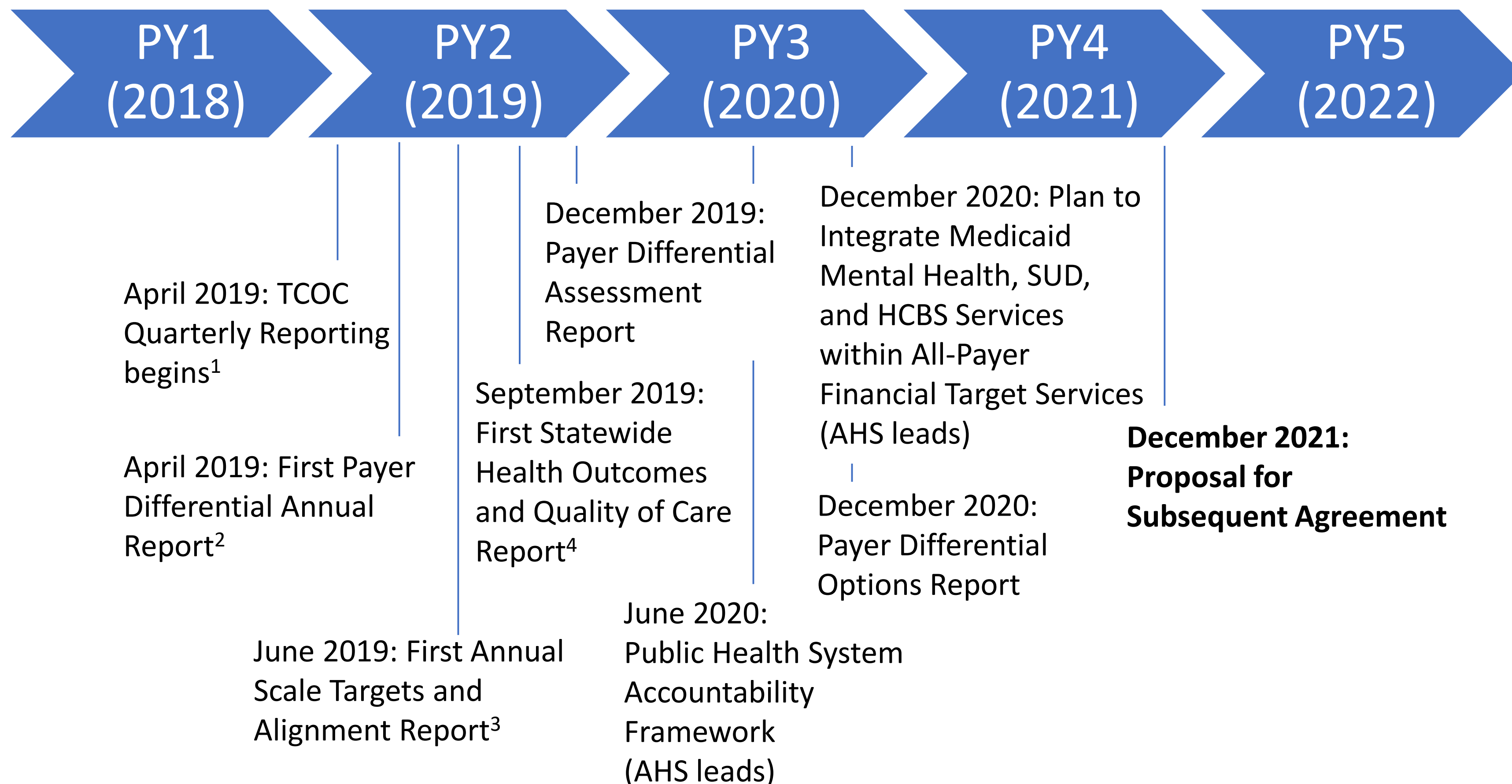
For PY 2-5, CMS and Vermont are collaborating to design and implement the **Vermont ACO Medicare Initiative*:**

Design alignment:
- Attribution (beneficiary alignment methodology)
- Payment mechanisms
- Risk arrangements
- ACO quality measures

Each year, CMS and Vermont agree on:
- Benchmark growth rate and how it ties to quality performance
- ACO quality measures
- Additional operational changes

* In Year 1, Medicare participated in the APM through the Vermont Modified Next Generation Program, with GMCB setting the trend rate subject to CMS approval. In Years 2-5, Medicare is participating through the Vermont Medicare ACO Initiative (which allows Vermont to seek additional modifications).

APM Reporting Timeline



[1] Submitted quarterly (reports produced 9 months following final date of service); annual reports completed in September of following year. Q12018 report delayed due to data availability. [2] Submitted annually on 4/1; April 2019 report delayed due to data. [3] Submitted annually on 6/30. [4] Submitted annually on 9/30.

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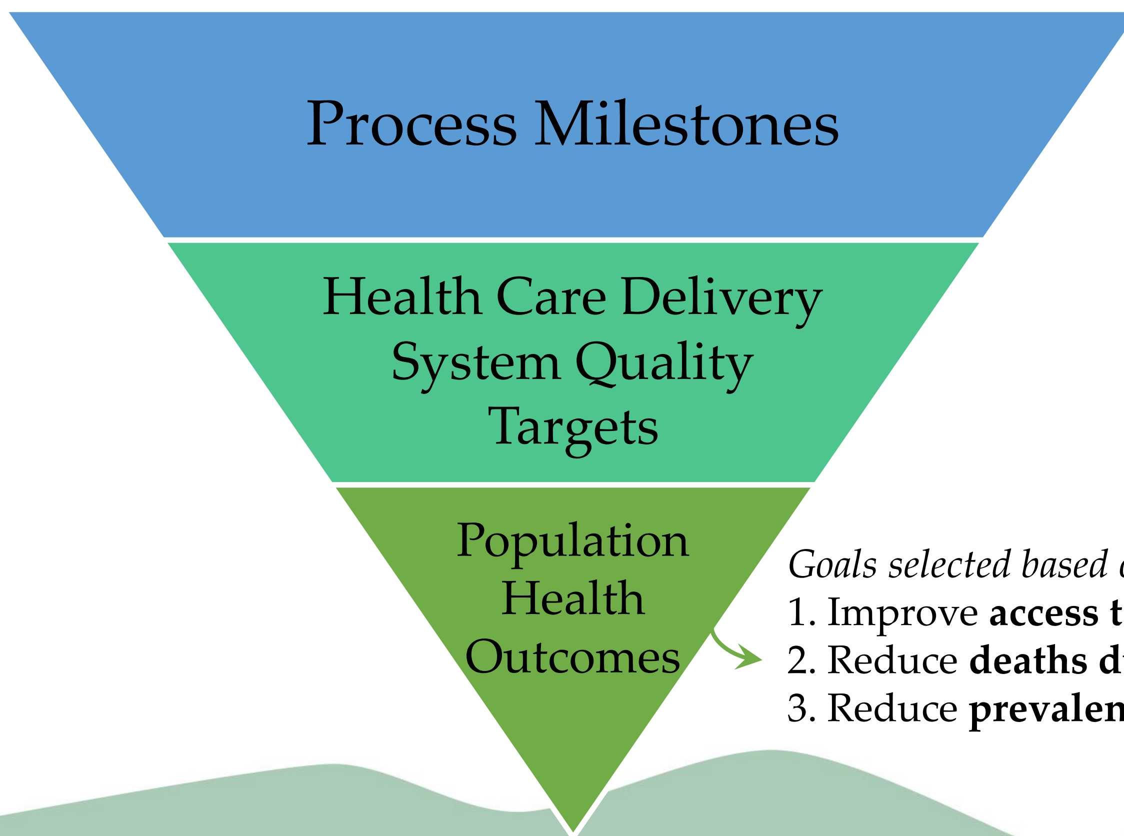
Improving the Health of Vermonters

How will we measure success?

- Vermont is responsible for meeting targets on **20 measures** under the Model

Process Milestones and **Health Care Delivery System Quality Targets** support achievement of ambitious **Population Health Goals**



Goals selected based on Vermont's priorities:

1. Improve **access to primary care**
2. Reduce **deaths due to suicide and drug overdose**
3. Reduce **prevalence and morbidity of chronic disease**

Statewide Health Outcomes and Quality Of Care Targets

- Complete data on Performance Year 1 (2018) is not yet available
- Reporting on Statewide Health Outcomes and Quality of Care Targets will begin in September 2019 for the 2018 performance year

Scale Targets and PY1 and PY2 Preliminary Scale Performance

Final Performance Year 1 scale performance = reported June 2019
Final Performance Year 2 scale performance = reported June 2020

	PY1 (2018)	PY2 (2019)
Medicare Scale Target	60%	75%
Medicare Scale Performance	35%	51%
All-Payer Scale Target	36%	50%
All-Payer Scale Performance	20%	30%-40%*

*PY2 Commercial Self-Funded numbers are preliminary; contracts with four self-funded commercial plans are still in negotiation. Ranges represent approximate totals across these potential contracts and potential impact on Commercial Scale and All-Payer Scale.

	PY1 (2018)	PY2 (2019)	PY3 (2020)	PY4 (2021)	PY5 (2022)
Medicare Scale Target	60%	75%	79%	83%	90%
All-Payer Scale Target	36%	50%	58%	62%	70%

Financial Targets: Total Cost of Care Reporting

- The Agreement measures per person growth in the Total Cost of Care (TCOC) for two populations:

  1. Medicare beneficiaries attributed to the ACO (Medicare TCOC)
  2. Vermont residents with claims data in VHCURES (All-Payer TCOC)

- All spending counts, whether the care was delivered in or out of the ACO's network (including out-of-state spending):
  - Claims-based spending
  - Nonclaims-based spending (e.g. Blueprint payments, Medicaid prospective payments, shared savings/losses)

Medicare TCOC Growth

- The per person Medicare spending for the ACO population will be compared to that of the population who *would have been attributed in 2017* based on the current (2018) provider list.

$$\frac{Actual\ Medicare\ spending\ for\ ACO\ population\ in\ 2018}{Actual\ Medicare\ spending\ for\ comparison\ population\ in\ 2017}$$

- Vermont will be on track if the spending growth is 3.5% or less because the Board elected to use the floor in setting the 2018 target.

Medicare TCOC Growth

- GMCB is relying on a data feed from the Medicare Next Generation program while the mapping of elements to VHCURES is being completed.
- The magnitude and direction of the data should be similar, but the values *will change*.

			Q1	Q2	Q3	Q4	YTD (Q1 and Q2)
PY 1	Reference Year (2017)	TCOC/Beneficiary (PMPM)	$804.66	$832.17	$790.80	$817.87	$818.34
		Numerator ($)	*$77,723,729*	*$79,443,281*	*$74,754,228*	*$76,599,842*	*$157,167,010*
		Denominator (Members)	*32,197*	*31,822*	*31,510*	*31,219*	*32,010*
	PY (2018)	TCOC/Beneficiary (PMPM)	$826.45	$840.66			$833.52
		Numerator ($)	*$91,019,555*	*$91,550,020*			*$182,569,576*
		Denominator (Members)	*36,711*	*36,301*			*36,506*
Year-to-Date Annual Per Beneficiary Growth Rate							**1.9%**
PER BENEFICIARY GROWTH – PERFORMANCE PERIOD TO DATE							***1.9%***

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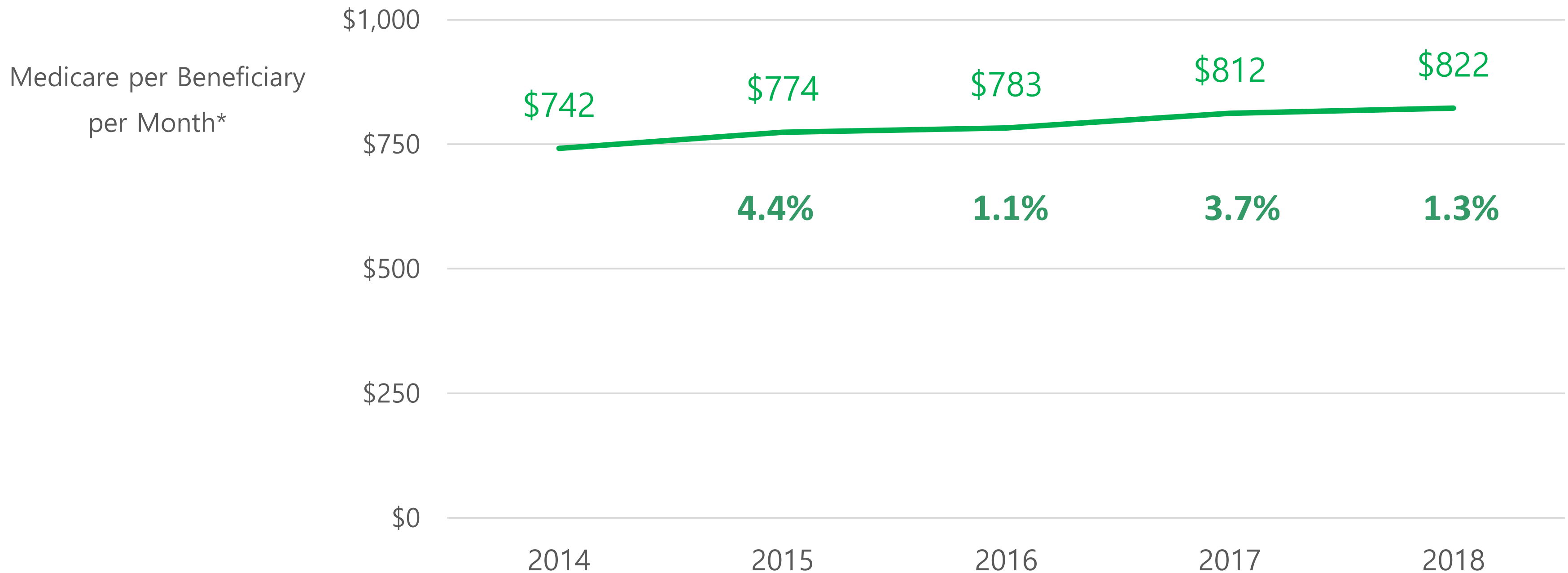
Claims-Based Medicare TCOC Growth Trend



* Paid amounts for services incurred through June and paid through December, based on beneficiaries who *would have been attributed* to the ACO based on the 2018 provider list.

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All-Payer TCOC Growth

- All-Payer per person spending in 2018 will be compared to 2017.
- Vermont will be on track if the spending growth is 3.5% or less, this target will remain the same for the life of the agreement.
- Includes estimated adjustments for Medicaid price increases (excluded per All-Payer ACO Model Agreement).

		Q1	Q2	Q3	Q4	YTD (Q1 and Q2)
Baseline (CY 2017)	TCOC/Beneficiary (PMPM)	$496.70	$504.13	$486.67	$496.99	$500.42
	Numerator ($	*$682,332,324*	*$694,883,028*	*$668,519,805*	*$680,262,606*	*$1,377,215,352*
	Denominator (Member)	*457,911*	*459,461*	*457,889*	*456,255*	*458,686*
Current PY (2018)	TCOC/Beneficiary (PMPM)	$517.97	$507.68			$512.83
	Numerator ($)	*$717,498,806*	*$701,550,665*			*$1,419,049,472*
	Denominator (Members)	*461,738*	*460,627*			*461,182*
	Per Beneficiary Growth Rate	***4.3%***	***0.7%***			***2.5%***

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TCOC Growth Targets

Medicare

- Compounding annualized growth rate; must be 0.2% below national projections for the five-year Agreement period.

All-Payer

- The baseline year for the All-Payer target remains fixed in 2017, which means the goal for 2022 is known.

2017 Annual All-Payer PMPM	$496
2022 All-Payer Target (3.5% growth)	**$591**
Trigger for Corrective Action (more than 4.3% growth)	*$614*

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Questions from Board

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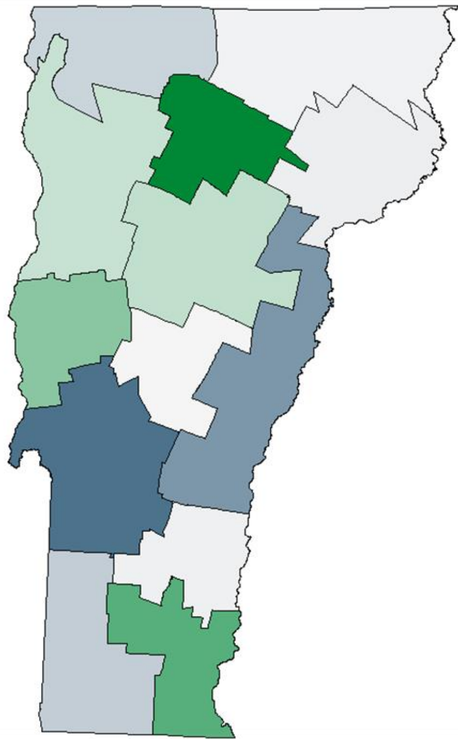

Demonstration:
Interactive Total Cost of Care Tool

April 10, 2019

David Glavin
Jessica Mendizabal

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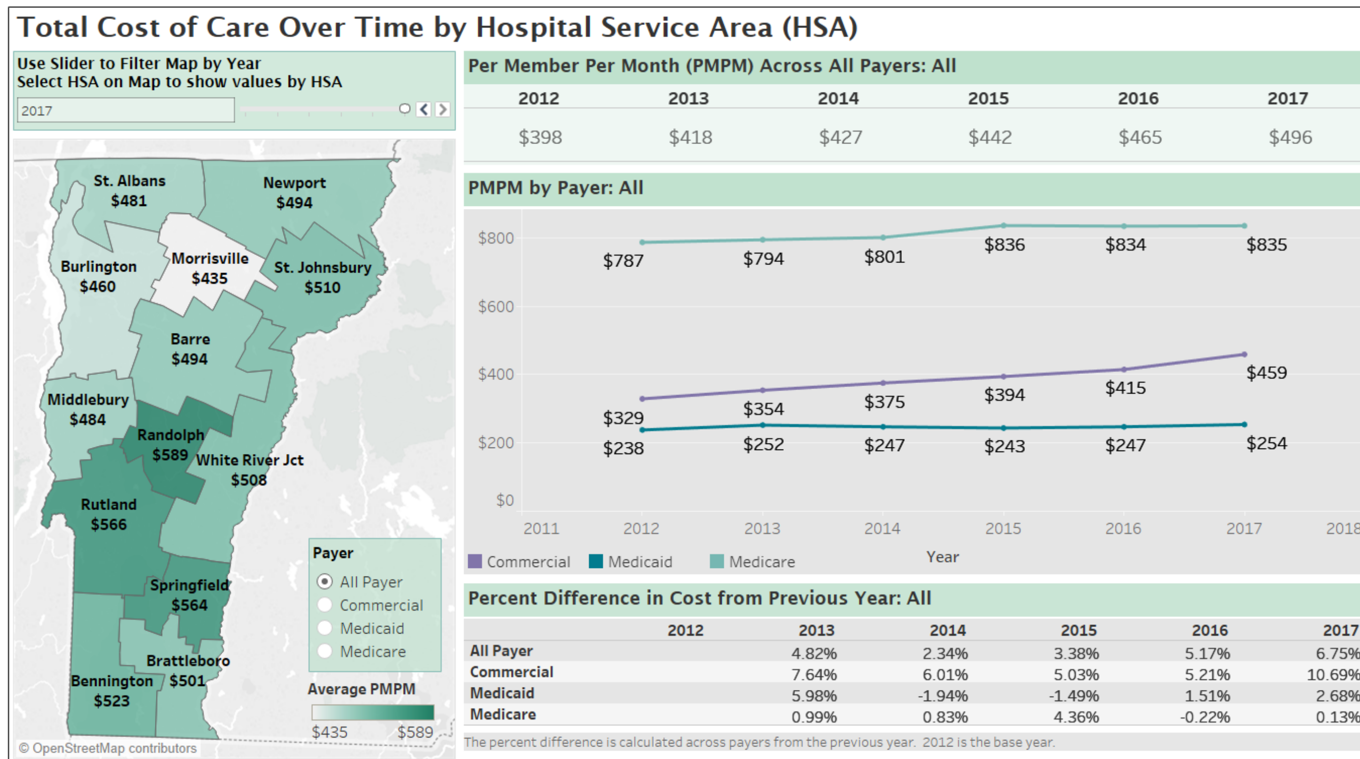
All-Payer TCOC

- The A Team is delighted to introduce a new, interactive tool for investigating the TCOC!



2012	2013	2014	2015	2016	2017
$398	$418	$427	$442	$465	$496

	2012	2013	2014	2015	2016	2017
All Payer		4.82%	2.34%	3.38%	5.17%	6.75%
Commercial		7.64%	6.01%	5.03%	5.21%	10.69%
Medicaid		5.98%	-1.94%	-1.49%	1.51%	2.68%
Medicare		0.99%	0.83%	4.36%	-0.22%	0.13%

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Questions and public comment

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